# Utah State Hospital Medical Records On-Line Manual

## Chapter: Medical Records (MR)

## Section 1: Plan for Services

**Medical Records**

Medical Records is adequately staffed and equipped to properly collect, analyze, and manage health information data.

Medical Records is managed by an Registered Health Information Technician and staffed with a records technician. The department's regular working hours are 8 a.m. to 5 p.m. weekdays.

**Filing System**

All first admissions are assigned a unique hospital number from e-Chart. Medical records are filed according to a terminal digit filing system. Records are filed numerically according to the patient's hospital number, found on the upper right corner of the patient's master index card. Discharged patient master index cards are located in the file cabinet labeled "discharged patients." Current patient master index cards are filed in the drawer labeled "current patients." Records are filed by the last two numbers of the patient's hospital number. The records are color coded according to the second to the last number, then tagged by the last number. Example: hospital number 01-0123. The record is coded with a yellow label (corresponding with the 20s) with a black tag covering the number 3. There are 100 different sections on the shelves and the record is filed in section 23.

**Patient Master Index Card**

The master index card includes the patient name, social security number, hospital number, birth date, unit, commitment status, and admission and discharge dates.

**Cross Reference File**

The cross reference cards are filed in the Cross Reference File numerically by social security number. Pseudo Number (900 plus the hospital number, ex. 900-01-0123) cards are filed alphabetically in the current patient file.

**Removal of Records from Medical Records Services**

Before hospital personnel remove a medical record, a Medical Records technician takes the yellow locator card out of the chart pocket and records on the card the date, unit, and name of the person picking up the chart. The card is filed alphabetically in the yellow locator card file. When the chart is returned, a Medical Records technician pulls the card from the file, notes the return date, and signs his/her initials. The person taking the record is responsible for the record. To access medical records after regular working hours, hospital personnel contact the Security Officer or Shift Supervising RN on duty. He/she is responsible for screening those who want access to medical records. If the record is removed from Medical Records, the Security Officer completes the yellow card and leaves it on the Manager's desk.

**Computerized Records**

A computer database is maintained on each patient.

**Computer and Confidentiality**

Confidentiality of medical records is built into the USH computer system. Personnel have access to information stored in the computer by using a coded password.

**Confidentiality**

Medical records are confidential. They are the property of the Utah State Hospital and are maintained for the benefit of the patients, the clinical staff, and the hospital. It is the responsibility of the hospital to safeguard the record against loss, defacement, tampering, or use by unauthorized persons. Violations of confidentiality may compromise treatment effectiveness. Except as provided by law, the proper written consent of the patient or his/her legal representative or attending physician is required for the release of medical information

**Requests**

All requests for medical records are directed to the Medical Records department of the Utah State Hospital (UA R525-001-9).

**Release of Information**

Release of information from a medical record is carried out by Medical Records personnel in accordance with all applicable legal, accrediting, regulatory agency requirements and in accordance with written hospital policy (UAC R525-001, Utah Code 62A-12-247).

**Limitations on Information Released**

Information released to authorized individuals/agencies is strictly limited to that information required to fulfill the purpose stated on the authorization. Authorization specifying “any and all information” or other such broadly inclusive statements are not honored. Releases of information that are not essential to the stated purpose of the request are specifically prohibited (UHA, Confidentiality, “Release of Information”) (CFR 42 Part 2, UC 62A- 12-247, UAC R525-001-12).

**Retention of Signed Authorization**

Following authorized release of patient information, the signed authorization is retained in the medical record with notation of the specific information disclosed, the date of the disclosure, and the initials of the individual disclosing the information (UAC R525-001- 16).

**Release of Information of a Deceased Person**

To release information of a deceased person, a

**Deficiencies in Authorization**

Deficient authorizations are returned to the sender with a letter stating the deficiencies of the authorization.

The Office of Recovery Services (ORS) may have full access to court papers, if a party to the proceedings has applied for or is receiving public assistance. ORS, as an agent of the department and a real party in interest, may have access to court filed in juvenile court cases. ORS and its agents treat all court records as confidential and do not release them to third parties without compliance with applicable state laws.

**Telephone Requests**

Disclosures of information are not given over the telephone, unless the

disclosure is deemed by Medical Records personnel to be an emergency (UAC R525-001-10).

**Attorney-At-Law**

An attorney-at-law duly licensed to practice in the State of Utah is authorized to represent the interests of a patient of any physician, surgeon, dentist, osteopathic physician, registered nurse, psychologist, chiropractor, or licensed hospital. Records are made available at the hospital for inspection and copying, if he/she presents a written authorization signed and acknowledged by the patient before a notary public; or in the case of a minor, by a parent or guardian; or in the case of a deceased patient, by the personal representative or heir. Such records remain in the possession of the hospital, and the attorney pays for all copies made at his/her request (Regulations & Utah State Board of Mental Health Policies, 78-25-25).

**Request for Entire Chart by Subpoena or Court Order**

A complete medical record is not released without first contacting the Utah State Hospital's Representative from the Attorney General's Office for direction.

**Research**

The researcher contacts the Manager of Research and completes a Research Application to submit to Medical Records. Research that involves new patient data requires signed consent from the patient.

**Fee for Copies of Records**

The fee schedule for copies of records is $1.00 per page.

**Patient Identification Cards**

Personal identification of patients such as a Social Security Card or Discharge Papers from the United States Armed Forces are returned to the patient upon request.

**News Media**

Patient information is confidential. All requests from the news media are referred to the Public Relations Officer.

**Expungement of Record**

The Utah State Hospital expunges a medical record upon receipt of an "Order Expunging Record" from the court. The expunged record is sealed (UAC R525-001-14).

**Expungement Procedure**

1. Check the request for appropriate signature and date.
2. Obtain the patient index card.
3. Place the medical record, court order, patient index card, and social security cross index card in "Expunged Record" file in the Medical Records department.
4. Make a new patient index card showing only the name, social security number, and hospital number. Indicate "Expunged Record" and make a new social security cross index card indicating the same.
5. For any inquiries, reply, "We have no record of the patient."
6. Return the "Notice of Expungement Order and Certification of Service with Acknowledgment" to the court within 30 days as indicated.

**Expungement Procedure for Microfilmed Records**

Same as “Expungement Procedure” above except for #4, which is as follows:
4. Place the court order, patient index card, and social security cross index card in an envelope marked “Expunged Record” and place in the “Expunged Record” file in the Medical Records department.

**Medical Record Content**

Medical records contain identification data as follows: name, home address, home telephone number, date of birth, sex, race or ethnic origin, next of kin, education, marital status, type and place of employment, date of initial contact or admission to the facility, legal status with relevant legal documents, other identifying data as indicated, date the information was gathered, and signature of the staff member gathering the information. When information is unobtainable, the reasons are noted.

**Physician’s Orders**

All medical orders are in writing and signed by a physician or registered nurse practitioner. Telephone orders are taken by a registered nurse and signed by the physician as soon as possible. The physician or registered nurse practitioner prescribes appropriate medications or treatment for the patient as necessary per the telephone. The doctor signs the telephone as soon as possible.
Physician’s orders are noted by two nurses (at least one RN) and include the following information:
1. Prescribing physician or registered nurse practitioner,
2. Date and time prescribed,
3. Drug and strength and/or treatment procedure,
4. Complete directions.

**Consents**

As necessary, the medical record contains documentation of the consent of the patient, appropriate family members, or guardians for admission, treatment, evaluation, aftercare, or research.

**Diagnosis**

A provisional diagnosis and primary diagnosis is made on every patient. The medical record contains both physical and emotional diagnoses that have been made, using the terminology of the American Psychiatric Association’s Diagnostic and Statistical Manual 111-R and International Classification of Diseases, Ninth Revision, Clinical Modification.

**Progress Notes**

Progress notes are recorded by the clinical staff involved in active treatment modalities. Their frequency is determined by the condition of the patient, but is recorded at least weekly for the first eight weeks and at least once a month thereafter. The notes contain recommendations for revisions in the treatment plan as indicated and precise assessments of the patient’s progress in accordance with the original or revised treatment plan.

**Symbols and Abbreviations**

Symbols and abbreviations are used only when they have been approved by the Medical Records Committee and only when there is an explanatory legend. Symbols and abbreviations are not used in the recording of diagnoses or on the discharge summary.

**Unusual Occurrences**
The medical record contains information on any unusual occurrences, such as the following: treatment complications, accidents or injuries to the patient, morbidity, death of a patient, and procedures that place the patient at risk or that cause unusual pain.

**Correspondence**
The medical record contains correspondence concerning the patient's treatment, and signed and dated notations of telephone calls concerning the patient's treatment.

**Discharge Summary**
The discharge summary includes a recapitulation and recommendations from appropriate services concerning follow-up and a plan for aftercare as well as a brief summary of the patient's condition on discharge. The discharge summary is entered in the medical record within a reasonable period of time not to exceed 30 days following discharge.

**Death Summary**
A Death Review Conference is held for patients who die at Utah State Hospital or who die while on Medical Separation status, or who die within 10 days of discharge. The Death Review Report is kept in Medical Records. Deaths that occur at USH are reported to the Medical Examiner (UCA 26-4-7, Health Code).

**Psychiatric Assessment**
The psychiatric assessment, including a medical history, contains a record of mental status, the onset of illness, the circumstances leading to admission, attitudes, behavior estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative fashion.

**Social History**
The social history report, including reports of interviews with patients, family members, and others, provides an assessment of home plans, family attitudes, and community resource contacts.

**Various Reports**
Reports of consultations, psychological evaluations, special studies, and medical/surgical services are included in the record.

**Individual Comprehensive Treatment Plan (ICTP)**
The individual comprehensive treatment plan is based on the assessments and evaluations of the interdisciplinary team members. The plan is based on an inventory of the patient's strengths and limitations and includes a substantiated psychiatric diagnosis in the terminology of the APA's DSM-IV-TR. Short- and long-term goals are established and specific treatment modalities are incorporated. Documentation by interdisciplinary team members justifies the psychiatric diagnoses, treatment modalities, and rehabilitation activities.

**Microfilming**
Medical Records personnel microfilm any medical record over five years old, whether the patient is at the hospital or not. A quality check is done on the microfilm. The patient's index card is marked with the microfilm roll number. Records of deceased patients can be microfilmed after one year.

After microfilming and checking for quality of the film the hard copy of the record is shredded.

## Section 2: Admission ProcessChapter: Medical Records (MR)
## Section 2: Admission Process

**AKA CARDS**

Patients readmitted with a different name. An AKA card (also known as) is created
referring medical record personnel to the patients previous name used at Utah State
Hospital.

**ADDITIONAL BROWN CHARTS**

When additional brown charts are needed by a unit, personnel from the unit will notify medical records of their need.

1. Check the current patients drawer's yellow card file to decide what number of chart will be made.
2. Make a brown chart and make a yellow locator card, numbering the chart correctly.
3. Send the brown chart to the appropriate nit and file the yellow locator card in the current patient yellow card file.

**ADMISSION PROCESS**

All original civil court papers are filed at the county court house after making photo copies. The photo copies are placed in the chart. Criminal patient legal papers do not need to be filed at the court house.

Before assigning a hospital number, check the master patient card index and the social security number card index to see if the individual has been prior patient.

**FOR A FIRST ADMISSION:**

- Assign a hospital number from the DSI computer program and write the number on the face sheet. Make 2 copies of Face Sheet and two copies of the remaining papers. Give 1 of the face sheet and l copy of the legal papers to the collection office. Give 1 copy of the face sheet and legal papers to the data technician of the Medical Records Department.
- The face sheet and court papers are filed in the chart. To create a chart--type the patient's name and hospital number on a sticky label and place it on the chart, place a color coded label on the side of the chart, and then put a black tag on the color label that covers the last number of the patient's hospital number.
- Type a social security index card (sample on following pages).
- Make a patient index card (sample on following pages).
- Type a yellow locator card (sample on following pages).

**PREVIOUS ADMISSION:**

- Pull the patient index card and type the type of admission and the date of admission.
- Pull the chart. The previous hospital number is used for all admissions. If the record(s)
have been microfilmed, make a new chart and locator card. Make photo copies as above for distribution to the collection office and technician.

- Make prints from the microfilm of the discharge summary, psychiatric, psychological, and social history to send to the unit.
455r-4/91, revised 8/91, revised 8/92, revised 3/94
**Cross Reference Card (Social Security Card)**
**Table Goes Here**
**Patient Master Index Card**
**Table Goes Here**
**Yellow Locator Card**
**Table Goes Here**
**Utah State Hospital 7/92**
**Documentation Requirements for Forensic Evaluation Patients**
**Tabe Goes Here**

## Chapter: Medical Records (MR)
## Section 5: Microfilming

**Purpose and Overview**

The proper microfilming of patient records is an essential part of providing accurate and easily accessible patient information. Each step in the process, if followed correctly, assists the records personnel in tracking charts and will result in the creation of a complete and permanent record of an individual patient's treatment at the Utah State Hospital.

(Note: any reference to a patient chart in this document refers to the brown chart only.)

Except for the working charts of patients currently admitted to the hospital, all charts five years old or less are stored in the Medical Records room. These include current patient charts no longer used on the unit. It is the responsibility of Medical Records staff to accurately file, store, and keep track of these charts. Patient records eligible to be microfilmed are a minimum of five years old, except for deceased patient records which may be filmed one year following the death.

**How to Get Started--Boxing the Charts**

Approximately every six months or when the shelves become too crowded, charts are pulled from the shelves and boxed, earmarking them for microfilming. First, boxes are assembled and renumbered according to the last box number, recorded in the pink binder marked "Microfilmed Patient Charts" in the microfilm room. If the last box number is 305, begin numbering at 306. Numbers are printed clearly and largely on the front and back of the box, making sure that old numbers are blacked out.

Because charts are filed in a numerical sequencing system, the number of the last chart pulled from the last box is used to begin a new round of boxing. This number is recorded on the last page of the pink binder. For instance, if 02-7751 is the last chart in Box 305, 02-7751 is also the point on the shelves to begin again, pulling only those charts over five years old.

Boxes should be full but not too tightly filled. The number of charts per box will vary from about five to 15, depending on the size of the charts. When a box is full, the yellow chart identification card in front of each chart is removed and kept in the same numerical order as the charts are placed in the box. These cards

contain the patient's name, patient, number, Social Security number, etc. Information from these cards is transferred to a sheet of paper kept in the microfilm room in a manila folder labeled "Sheets for Boxed Records and Name Strips." Put new box number on top of form. Using large and legible hand print, transfer information from the patient yellow card to record sheet as follows: Complete a line on the sheet for every patient chart pulled in that box. If one patient has more than one chart in the box, you need only write their name and patient information once; however, indicate somewhere on the line how many charts are in the box for that patient.

Box 306

LAST NAME, First Middle Social Sec. Number Patient Number
(2 charts)

When this is completed, make one copy of the sheet. Place the copy in the top of the box before the lid is put on, use a three-hole punch on the original and place it in the back of the looseleaf in the cabinet. Make sure the numerical sequence of boxes is correct. The yellow cards that are pulled from the chart are marked with the corresponding box number and placed in the small file box in the microfilm cabinet in proper numerical order.

**The Storage Room**

The room currently used to store boxed charts that are ready to be microfilmed is behind and to the east of the stage in the Administration Building. The keys to this room and to the cabinets therein are kept in the right-hand drawer by the reception counter in Medical Records. When the steps above have been completed, the boxes are ready to be stored. Boxes should be taken to the storage room and placed in numerical order (or as close to it as possible).

**Getting Ready to Film**

Microfilm the boxes in numerical order. A list of all charts and patient numbers is in the top of the box and another exact copy is in a binder in the cupboard. When beginning a new box, copy this strip of paper with the patient information and cut it into strips along the lines. Strips will be approximately 1" wide. Insert the strip in each chart, making sure to match the names correctly. These strips will be filmed at the beginning of each chart. Place the information sheet on the clipboard to the left of the microfilm camera and indicate the current roll number next to the first name.

**Preparing the Charts for Filming**

Remove the next chart to be filmed from the box to separate for filming. If there are two or more charts on the same patient, check them carefully to be sure they are not the same admission. For instance, a patient may have three charts and only one admission and the charts must be combined by section (Legal, Assessment, Treatment, Medical, Physical, Miscellaneous) into one large record. Many charts will have more than one admission within a single chart, and if this is the case, admissions must be separated by category and combined to form a complete record of that admission. If the charts contain separate admissions, no combining is necessary, but be sure to use the First Admission, Second Admission, etc., cards at the beginning of the chart to indicate what admission number is being filmed.

When separating the sections in the chart before filming, at the beginning of each section insert the large card with the corresponding word for the section, i.e. “Legal” in the front of the first section, “Assessment” in front of the second section, etc. When there is more than one admission, place section identification cards in first admission, but indicate where sections on the other admissions start and end by using the pink cards found in the chart or by using Post-It notes. When ready to begin filming, chart should be completely separated with admission number cards at the beginning of each new admission and as many staples as are possible should be removed to expedite filming.

## Chapter: Medical Records (MR)

## Section 6: Releasing of Information

***Instructions***

**Releasing Confidential Information Work Outline**

All requests for information are directed to the Medical Records Manager for approval. The records technician performs the following:

1. Pull the chart or microfilm.
2. Copy the information indicated by the Medical Records Manager.

3. Stamp top page of information to be released: Unauthorized, use, release, or duplication of this information by recipient is prohibited. Destroy all copies after authorized need has been fulfilled.

Recipient:
From:_____ Date UTAH STATE HOSPITAL

4. Complete as appropriate.

5. Stamp all other pages: Unauthorized use, release, or duplication of this information by recipient is prohibited. Destroy all copies after authorized need has been fulfilled.
6. Record in the log request book the date received, patient name, date sent, documents released, agency and person receiving information, address, records technician initials, and number of pages.
7. Address envelope to mail information.
8. Document on the release: the date sent, information sent, and your signature.
9. File the request in the patient’s record in the Legal section. If the request is for microfilmed records, file it in the microfilm folder.
10. File the record back on the shelf or the microfilm roll back in the drawer.
11. Place mail in the business office mail deposit.

455R-8
6/89, revised 8/92

Costs of searching for documents, the costs of reviewing documents to determine whether they should be released, and the costs of segregating information within a document so that some information may be released while other information is withheld." 7/31/92 letter to Norm Angus from John Clark, Counsel to the Attorney General.
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## Chapter: Medical Records (MR)
## Section 7: Discharge Process
**Discharge Process**

THINNING GUIDELINES
A. Identification All
B. Physicians Orders All if possible - six months minimum
C. ICTP Most recent and last six months
D. Progress Notes/SPN's/ Six Months
Restraint and Seclusion
E. Activities of Daily Living Two Months
F. Assessments Original and current (all disciplines)
Current physical exam
G. Lab, EEG Most recent - and one year (exceptions can be made)
H. Consultation/Dental All Neurological. Most current dental sheet, eye exam, podiatry consults.
I. Medication Sheets Current month of medication sheets are on file in the med book. Three months.
J. Diabetic Records Most recent and three months
K. Flow Sheet Summary sheet - (vital signs, weight)
L. Physical Therapy One year
M. Valuables List All
N. Court Papers Copies as needed, originals in permanent record
Under the direction of the Supervising Nurse, a delegated person uses the above guidelines when thinning a chart. A note should appear in the progress notes of the working chart summarizing the information placed in the permanent record in cases involving medical illness etc.
Pertinent medical information obtained on request from outside sources is filed with, but not necessarily as part of the patient's medical record. Such information is available to professional staff concerned with the care and treatment of the patient.